

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/05/2012

IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

outpatient medial unicompartment replacement as related to the left knee

### A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

M.D., Board Certified Orthopedic surgery

### REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

### Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

The reviewer finds that medical necessity does not exist for outpatient medial unicompartment replacement as related to the left knee.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines  
Notice of utilization review findings 06/05/12  
Notice of utilization review findings 06/12/12  
Notice of utilization review findings 05/24/12  
Notice of utilization review findings 06/08/12  
Progress record Dr. 05/30/12  
Operative report left knee arthroscopy 01/12/12  
X-rays left knee 05/30/12 and 12/20/11  
MRI left knee 12/20/11 and 04/13/12  
management response to IRO 06/18/12  
Notice of work related injury / illness Texas Department of Criminal Justice 12/20/11  
Notice of disputed issues and refusal to pay benefits 12/30/11  
examination left lower extremity 01/25/12  
Hospital District progress note ER 12/20/11  
Office notes Dr. 12/22/11 and 12/28/11  
Office notes Dr. 12/28/11-04/16/12  
Request for additional information 01/16/12  
Physical therapy progress notes 01/17/12-03/05/12  
Emergency department physician notes 01/25/12  
Peer review / medical records reviewed Dr. 01/14/12

### PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on when she slipped down a wet floor and fell onto her knee. She had left knee arthroscopy on 01/12/12 with excision of tears and medial meniscus; debridement of chondromalacia of patella and medial femoral condyle. She

participated in postoperative physical therapy. She continued to complain of medial knee pain and swelling. Repeat MRI of the left knee was performed on 04/13/12 and revealed a large amount of abnormal marrow edema had developed involving entire medial femoral condyle and entire medial tibial plateau. This is greater in degree than what is expected with standard advanced osteoarthritic changes. Other superimposed processes such as infectious or inflammatory etiology are not excluded. Abnormal marrow signal seen in tibial plateau which, demonstrates horizontal orientation and abnormal signal on T1 weighted images suspicious for macrofracture.

There are findings suspicious for interval partial meniscectomy involving posterior horn of medial meniscus. Severe osteoarthritic changes involving medial compartment including near complete loss of cartilage and bone on bone alignment and osteophytic spurring also noted. Moderate sized Baker's cyst was present, with suspected loose bodies within Baker's cyst. Severe retropatellar chondromalacia was present, as well as moderate sized knee joint effusion. The claimant was seen on 05/30/12 by Dr. Examination at that time revealed the claimant to be 5'4" tall and 185 lbs. She walks with antalgic gait utilizing cane for ambulation. She has mild swelling in left knee. There is +1 medial pseudolaxity. There is crepitus with knee range of motion and pain with patellofemoral compression. She has mild flexion contracture with further flexion of 110 degrees. There is full range of motion of both hips without pain and full lower extremity muscle strength bilaterally. There is no swelling, pitting edema, or skin ulceration or breakdown in either lower extremity. Sensation is intact to light touch in both feet. Radiographs of the left knee showed medial compartment narrowing, progressive since initial radiographs taken in 12/11. The claimant was noted to have failed arthroscopic debridement and conservative treatment including physical therapy for her traumatic arthritis of left knee. She was recommended to undergo knee replacement surgery / medial unicompartmental replacement.

The request for medial unicompartment replacement to left knee was denied by utilization review on 06/05/12. The reviewer noted the claimant had arthroscopy on 01/12/12. Regarding meniscal replacement it was noted ODG notes in an RCT comparing collagen meniscus implant with partial meniscectomy, the implant was not found to have any benefit for patients with acute injury. In 09/09 review of Menaflex, the FDA concluded that departures from processes, procedures, and practices leave the basis for the above review decision in question.

A reconsideration request for outpatient medial unicompartment replacement as related to left knee was non-authorized on utilization review dated 06/12/12. Reviewer noted there was no documentation of viscosupplementation injections or steroid injection, and the records and evidenced based citations do not support certification of the request.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The claimant sustained an injury when she slipped and fell on wet floor injuring her left knee. She is status post left knee arthroscopy on 01/12/12 with excision of medial meniscus and debridement of chondromalacia of patella and medial femoral condyle. The claimant remained symptomatic following postoperative physical therapy. Repeat MRI revealed postoperative changes of partial medial meniscectomy and progression of osteoarthritic changes. Plain radiographs of left knee on 05/30/12 were noted to show medial compartment narrowing. As noted on previous review there is no documentation the claimant has had a trial of viscosupplementation and / or corticosteroid injections to the left knee. According to Official Disability Guidelines, knee arthroplasty is indicated if the following criteria are met: conservative care with medications and viscosupplementation or steroid injection; plus subjective clinical findings including limited range of motion and night time joint pain, and no relief with conservative treatment, and documentation of functional limitations; plus objective findings over 50 years of age and body mass index less than 35; plus osteoarthritis on standing x-ray or arthroscopy. Noting the claimant has not failed conservative treatment including unloader brace, viscosupplementation injections and / or steroid injections, the reviewer finds that medical necessity does not exist for outpatient medial unicompartment replacement as related to the left knee.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

☐ ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)